		FOR OHF USE					

LL1

2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0007344

Facility Name: CARROLL COUNTY GOOD SAMARITAN CENTER

Address: 1006 N LOWDEN RD, PO BOX 8 (Number) MOUNT CARROLL (City) 61053 (Zip Code)

County: CARROLL

Telephone Number: (815) 244-7715 **Fax #** (815) 244-3127

IDPA ID Number:

Date of Initial License for Current Owners: 1/1/1970

Type of Ownership:

- [X] VOLUNTARY,NON-PROFIT
  - [X] Charitable Corp.
  - [ ] Trust
- [ ] PROPRIETARY
  - [ ] Individual
  - [ ] Partnership
  - [ ] Corporation
  - [ ] "Sub-S" Corp.
  - [ ] Limited Liability Co.
  - [ ] Trust
  - [ ] Other
- [ ] GOVERNMENTAL
  - [ ] State
  - [ ] County
  - [ ] Other

IRS Exemption Code

In the event there are further questions about this report, please contact:
Name: KIM KOURI **Telephone Number:** (605) 362-3178

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2005 to 12/31/2005 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) RAYE NAE NYLANDER

(Title) VICE PRESIDENT/CFO

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number CARROLL COUNTY GOOD SAMARITAN CENTER # 0007344 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	72	Skilled (SNF)	72	26,280	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	72	TOTALS	72	26,280	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	11,935	10,652	1,570	24,157	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,935	10,652	1,570	24,157	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.92%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
MEALS ON WHEELS

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 01/01/1970

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary CAHABA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2005 Fiscal Year: 12/31/2005

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number CARROLL COUNTY GOOD SAMARITAN # 0007344 **Report Period Beginning:** 1/1/2005 **Ending:** 12/31/2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	148,914	10,832	4,747	164,493		164,493	(177)	164,316			1
2	Food Purchase		121,545		121,545		121,545	(11,968)	109,577			2
3	Housekeeping	69,579	11,690		81,269		81,269	(194)	81,075			3
4	Laundry	50,522	8,303		58,825		58,825	(141)	58,684			4
5	Heat and Other Utilities			77,230	77,230		77,230		77,230			5
6	Maintenance	32,416	7,982	30,002	70,400		70,400	(341)	70,059			6
7	Other (specify):*			4,217	4,217		4,217	(354)	3,863			7
8	**TOTAL General Services**	301,431	160,352	116,196	577,979		577,979	(13,175)	564,804			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,061,511	100,640	3,641	1,165,792	(4,265)	1,161,527	(39,950)	1,121,577			10
10a	Therapy		860	140,411	141,271		141,271	(59,887)	81,384			10a
11	Activities	51,000	2,150	10,790	63,940		63,940	(6,215)	57,725			11
12	Social Services	29,495	30	2,774	32,299		32,299		32,299			12
13	CNA Training					4,265	4,265		4,265			13
14	Program Transportation			3,411	3,411		3,411		3,411			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,142,006	103,680	161,027	1,406,713		1,406,713	(106,052)	1,300,661			16
	C. General Administration											
17	Administrative	54,257		120,060	174,317		174,317	20,823	195,140			17
18	Directors Fees											18
19	Professional Services			14,483	14,483		14,483	(2,995)	11,488			19
20	Dues, Fees, Subscriptions & Promotions			15,959	15,959		15,959	(10,397)	5,562			20
21	Clerical & General Office Expenses	128,728	17,988	32,722	179,438		179,438	239	179,677			21
22	Employee Benefits & Payroll Taxes			354,725	354,725		354,725	(12,902)	341,823			22
23	Inservice Training & Education			10,301	10,301	(58)	10,243		10,243			23
24	Travel and Seminar			3,985	3,985	58	4,043	(2,856)	1,187			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			32,215	32,215		32,215	7,051	39,266			26
27	Other (specify):*			655	655		655		655			27
28	**TOTAL General Administration**	182,985	17,988	585,105	786,078		786,078	(1,037)	785,041			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,626,422	282,020	862,328	2,770,770		2,770,770	(120,264)	2,650,506			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number CARROLL COUNTY GOOD SAMARITAN CENTER #0007344 **Report Period Beginning:** 1/1/2005 **Ending:** 12/31/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			149,417	149,417		149,417		149,417			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			455	455		455	(455)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			3,844	3,844		3,844		3,844			35
36	Other (specify):*											36
37	**TOTAL Ownership**			153,716	153,716		153,716	(455)	153,261			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops		1,179		1,179		1,179	(1,179)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			39,004	39,004		39,004		39,004			42
43	Other (specify):*			3,669	3,669		3,669	(3,669)				43
44	**TOTAL Special Cost Centers**		1,179	42,673	43,852		43,852	(4,848)	39,004			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,626,422	283,199	1,058,717	2,968,338		2,968,338	(125,567)	2,842,771			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number CARROLL COUNTY GOOD SAMARITAN CENTER # 0007344 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(11,968)	2		4
5	Telephone, TV & Radio in Resident Rooms	(6,178)	11		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(455)	32		10
11	Discounts, Allowances, Rebates & Refunds	1,687	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(497)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(10,397)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(112,731)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (140,539)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	14,972		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 14,972		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (125,567)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

CARROLL COUNTY GOOD SAMARITAN CENTER

ID# 0007344

Report Period Beginning: 1/1/2005

Ending: 12/31/2005

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	POSTAGE	$ (36)	21	1
2	TRANSPORTATION	(1,599)	6	2
3	RESIDENT SUPPLIES	(354)	7	3
4	INT INC PAST DUE ACCTS	(25)	21	4
5	DEFERRED MAINTENANCE COSTS - 2005	1,305	6	5
6	BANK CHARGES	10	21	6
7				7
8	PROFESSIONAL SERVICES	(2,995)	19	8
9	PRESCRIPTION DRUGS - REIMB	(38,675)	10	9
10	SUPPLIES - RES DEV	(49)	21	10
11	MISC FUNDRAISER EXP	(655)	21	11
12	PURCH SERV - RADIOLOGY-MDCR	(1,216)	43	12
13	THERAPY OFFSET - PT, OT, ST	(59,575)	10A	13
14	PURCH SERV - LABORATORY-MDCR	(2,453)	43	14
15	PURCH SERV - CLINIC	(303)	10A	15
16	POSTAGE-MARKETING	(10)	21	16
17	BARBER/BEAUTY EXPENSE	(1,179)	40	17
18	TRAVEL - OUT OF STATE	(2,856)	24	18
19	DISCOUNT ALLOW - ADMIN	(186)	21	19
20	DISCOUNT ALLOW - NURSING	(890)	10	20
21	DISCOUNT ALLOW - PT	(9)	10A	21
22	DISCOUNT ALLOW - ADMIN	(4)	10	22
23	DISCOUNT ALLOW - ACTIVITIES	(37)	11	23
24	DISCOUNT ALLOW - LAUNDRY	(141)	4	24
25	DISCOUNT ALLOW - HOUSEKEEPING	(194)	3	25
26	DISCOUNT ALLOW - DIETARY	(177)	1	26
27	DISCOUNT ALLOW - OPERATIONS/MAINT	(47)	6	27
28	MED SUPPLIES -PART B	(381)	10	28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(112,731)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number CARROLL COUNTY GOOD SAMARITAN CENTER # 0007344 **Report Period Beginning:** 1/1/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(177)	0	0	0	0	0	0	0	0	0	0	(177)	1
2	Food Purchase	(11,968)	0	0	0	0	0	0	0	0	0	0	(11,968)	2
3	Housekeeping	(194)	0	0	0	0	0	0	0	0	0	0	(194)	3
4	Laundry	(141)	0	0	0	0	0	0	0	0	0	0	(141)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(341)	0	0	0	0	0	0	0	0	0	0	(341)	6
7	Other (specify):*	(354)	0	0	0	0	0	0	0	0	0	0	(354)	7
8	**TOTAL General Services**	(13,175)	0	0	0	0	0	0	0	0	0	0	(13,175)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(39,950)	0	0	0	0	0	0	0	0	0	0	(39,950)	10
10a	Therapy	(59,887)	0	0	0	0	0	0	0	0	0	0	(59,887)	10a
11	Activities	(6,215)	0	0	0	0	0	0	0	0	0	0	(6,215)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(106,052)	0	0	0	0	0	0	0	0	0	0	(106,052)	16
	C. General Administration													
17	Administrative	0	20,823	0	0	0	0	0	0	0	0	0	20,823	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,995)	0	0	0	0	0	0	0	0	0	0	(2,995)	19
20	Fees, Subscriptions & Promotions	(10,397)	0	0	0	0	0	0	0	0	0	0	(10,397)	20
21	Clerical & General Office Expenses	239	0	0	0	0	0	0	0	0	0	0	239	21
22	Employee Benefits & Payroll Taxes	0	(12,902)	0	0	0	0	0	0	0	0	0	(12,902)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(2,856)	0	0	0	0	0	0	0	0	0	0	(2,856)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	7,051	0	0	0	0	0	0	0	0	0	7,051	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(16,009)	14,972	0	0	0	0	0	0	0	0	0	(1,037)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(135,236)	14,972	0	0	0	0	0	0	0	0	0	(120,264)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number CARROLL COUNTY GOOD SAMARITAN CENTER # 0007344 **Report Period Beginning:** 1/1/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(455)	0	0	0	0	0	0	0	0	0	0	(455)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(455)	0	0	0	0	0	0	0	0	0	0	(455)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	(1,179)	0	0	0	0	0	0	0	0	0	0	(1,179)	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(3,669)	0	0	0	0	0	0	0	0	0	0	(3,669)	43
44	**TOTAL Special Cost Centers**	(4,848)	0	0	0	0	0	0	0	0	0	0	(4,848)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(140,539)	14,972	0	0	0	0	0	0	0	0	0	(125,567)	45

Facility Name & ID Number CARROLL COUNTY GOOD SAMARITAN CENTER # 0007344 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Ev Lutheran Good Samartian Society	100					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		17	ADMIN/ACCTG	$ 120,060	The Evangelical Lutheran Good Samaritan Society	100.00%	$ 140,883	$ 20,823	1
2	V		22	WORKERS COMP	56,595			50,183	(6,412)	2
3	V		22	UNEMPLOY CHARGES PD	6,373			6,399	26	3
4	V		26	INSURANCE	32,185			39,236	7,051	4
5	V		22	GROUP HEALTH INS	136,514			129,998	(6,516)	5
6	V									6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$ 351,727			$ 366,699	$ * 14,972	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number CARROLL COUNTY GOOD SAMARITAI # 0007344 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1			NOT APPLICABLE						$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number CARROLL COUNTY GOOD SAMARITAN CENTER # 0007344 Report Period Beginning: 1/1/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2				NO ALLOCATION NECESSARY						2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number CARROLL COUNTY GOOD SAMARITAN # 0007344 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10	Annuities						5,000	5,000			(455)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$ 5,000	$ 5,000			$ (455)	14
15	TOTALS (line 9+line14)						$ 5,000	$ 5,000			$ (455)	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number CARROLL COUNTY GOOD SAMARITAN CENTER # 0007344 **Report Period Beginning:** 1/1/2005 **Ending:** 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2004 report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	2000	8
	2001	9
	2002	10
	2003	11
	2004	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME CARROLL COUNTY GOOD SAMARITAN CENTER COUNTY CARROLL

FACILITY IDPH LICENSE NUMBER 0007344

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number CARROLL COUNTY GOOD SAMARITAN CENTER # 0007344 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,795 B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1			1968	$ 5,720	1
2					2
3	TOTALS			$ 5,720	3

Facility Name & ID Number CARROLL COUNTY GOOD SAMARITAN CENTER # 0007344 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1970	1970	$ 418,768	$ 10,470	40	$ 10,470	$	$ 376,017	4
5			1991	1991	912,129	39,246	Varies	39,246		724,583	5
6											6
7											7
8											8
	Improvement Type**										
9	Building										9
10											10
11				1971	382	9	Varies	9		329	11
12				1976	3,352					3,352	12
13				1979	5,570					5,570	13
14				1980	1,419					1,419	14
15				1981	33,937					33,627	15
16				1982	29,187		Varies			29,187	16
17				1983	8,193		Varies			8,193	17
18				1984	1,224					1,224	18
19				1985	14,500	604	Varies	604		14,500	19
20				1986	11,402	55	Varies	55		11,392	20
21				1987	15,273	543	Varies	543		14,290	21
22				1988	14,405	674		674		12,902	22
23				1989	35,790	180		180		35,177	23
24				1990	24,930	237		237		24,813	24
25				1992	10,950	518		518		7,845	25
26				1993	2,434					2,434	26
27				1994	48,103	963		963		41,755	27
28				1995	36,886	462		462		36,329	28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number CARROLL COUNTY GOOD SAMARITAN CENTER # 0007344 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Building		$	$		$	$	$	37
38	Compressor/Control Board	1996	2,027	135	15	135		1,352	38
39	Air Conditioning	1996	98,766	6,584	15	6,584		65,844	39
40	Return Air Ducts	1996	1,030	52	20	52		494	40
41	Roof	1996	75,405	3,770	20	3,770		35,189	41
42	Installation of Annumciator	1997	7,151		6			7,151	42
43	Installation of New Ambulance	1997	1,924	128	15	128		1,037	43
44	Replaced Roof	1997	11,920	596	20	596		4,818	44
45	Hand Rails	1998	5,049	337	15	337		2,637	45
46	Electric-Emergency Panel	1998	4,300	215	20	215		1,720	46
47	Wiring For Network	1998	6,096	305	20	305		2,210	47
48	Repair Roof	1999	1,325	132	10	132		960	48
49	Steel Door	1999	2,284	152	15	152		1,053	49
50	Alarm System	1999	20,000	2,000	10	2,000		12,833	50
51	Alarm System	1999	8,080	404	20	404		2,458	51
52	Electri-Maint Storage Building	2000	2,100	105	20	105		630	52
53	Maintenance Storage Building	2000	20,196	505	40	505		3,029	53
54	Water Heater	2000	3,500	350	10	350		2,013	54
55	Water Heater	2000	1,639	164	10	164		956	55
56	Piping & Wiring-Dishwasher	2000	2,180	218	10	218		1,217	56
57	Painting in Kitchen	2000	2,126	213	5	213		2,126	57
58	Building-Interior Renovations	2000	2,800	112	25	112		625	58
59	Painting-Interior Renovations	2000	637	53	5	53		637	59
60	Wallpaper-Interior Renovations	2000	15,389	1,282	5	1,282		15,389	60
61	Extensions of Firewall	2000	3,985	199	20	199		1,046	61
62	Carpet-Interior Renovation	2000	26,529	2,211	5	2,211		26,529	62
63	Oak Doors	2002	3,545	236	15	236		886	63
64	Wiring Redpt For Call Light	2002	663	66	10	66		210	64
65	Vertical Blinds	2002	510	102	5	102		323	65
66	Restroom Remodeling	2002	385	39	10	39		122	66
67	Window Replacement-Resident Rm	2002	28,542	1,903	15	1,903		6,025	67
68	Commercial Door	2002	509	34	15	34		107	68
69	Tile	2002	536	54	10	54		166	69
70	TOTAL (lines 4 thru 69)		$ 1,989,962	$ 76,617		$ 76,617	$	$ 1,586,730	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CARROLL COUNTY GOOD SAMARITAN CENTER # 0007344 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 1,989,962	$ 76,617		$ 76,617	$	$ 1,586,730	1
2	Building								2
3	Open Front toilet Seat	2002	568	28	20	28		90	3
4	Water Heater	2002	3840	384	10	384		1,152	4
5	Heater Covers	2002	9000	900	10	900		2,925	5
6	300 Wing Shower room tile	2003	599	60	10	60		150	6
7	Boiler System Replacement	2003	49162	2458	20	2458		5,940	7
8	Counter Top	2003	1508	75	20	75		182	8
9	Tile For 300 Wing Shower Room	2003	537	54	10	54		134	9
10	Locks	2003	399	40	10	40		96	10
11	Outside Door For Kitchen	2003	1326	88	15	88		184	11
12	Smoke Detectors	2004	1650	165	10	165		248	12
13	Cabinets for Activity	2004	4368	218	20	218		237	13
14	Window	2005	643	32	15	32		32	14
15	Exterior Door	2005	2,611	102	15	102		102	15
16	Heat/AC Unit	2005	2,800	70	10	70		70	16
17	AC Unit	2005	811	14	10	14		14	17
18	Blinds-Resident Room Remodel	2005	656	11	5	11		11	18
19	Building-Resident Room Remodel	2005	75,208	251	25	251		251	19
20	Drapes-Resident Room Remodel	2005	8,199	137	5	137		137	20
21	Wallpaper-Resident Room Remodel	2005	17,523	292	5	292		292	21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,171,370	$ 81,996		$ 81,996	$	$ 1,598,977	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CARROLL COUNTY GOOD SAMARITAN CENTER # 0007344 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 2,171,370	$ 81,996		$ 81,996	$	$ 1,598,977	1
2	Land Improvements								2
3		1970	3,703		15			3,703	3
4		1975	1,986		15			1,986	4
5		1977	185		15			185	5
6		1979	466		15			466	6
7		1980	140		15			140	7
8		1986	3,061		10			3,061	8
9		1988	3,474		15			3,474	9
10		1989	1,419		10			1,419	10
11		1991	98,154	5,877	varies	5,877		94,612	11
12		1993	2,560		10			2,560	12
13		1994	20,508	1,491	varies	1,491		17,125	13
14	Seal Cost Driveways and Parking	1997	3,050	153	20	153		1,296	14
15	Paving-Additional Parking Lot	1999	6,640	332	20	332		2,103	15
16	Lumber for Raised Garden	2000	330	33	10	33		184	16
17	Garden Beds	2000	1,650	110	15	110		605	17
18	Shrubs	2000	677	68	10	68		367	18
19	Driveway Repair	2000	4,455	446	10	446		2,376	19
20	Landscaping	2000	392	26	15	26		139	20
21	Repair Sidewalk	2002	4,270	427	10	427		1,459	21
22	Gazebo	2003	4,006	200	20	200		551	22
23	Fencing	2003	732	73	10	73		189	23
24	Stripping/Repair Parking Lot	2004	5,865	1,173	5	1,173		1,760	24
25	Concrete Work	2004	3,335	222	15	222		296	25
26	Shed	2005	398	33	10	33		33	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,342,826	$ 92,660		$ 92,660	$	$ 1,739,067	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CARROLL COUNTY GOOD SAMARITAN CENTI # 0007344 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 468,136	$ 43,144	$ 43,144	$		$ 233,634	71
72	Current Year Purchases	56,066	3,407	3,407			3,407	72
73	Fully Depreciated Assets	286,618	1,871	1,871			286,621	73
74	Disposal Laser Printer, Tower Fans		(128)	(128)				74
75	TOTALS	$ 810,820	$ 48,294	$ 48,294	$		$ 523,662	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident Care	Bus	2002	$ 42,763	$ 7,127	$ 7,127	$	6	$ 27,321	76
77		1994 4x4 Truck	2004	3,500	875	875		4	1,167	77
78		2002 Oldsmobile Silhouette	2005	15,173	632	632		4	632	78
79		Disposal - '78 Jeep Truck			(2,500)	(2,500)				79
80	TOTALS			$ 61,436	$ 6,134	$ 6,134	$		$ 29,120	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,220,802	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 147,088	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 147,088	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,291,849	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	CIP	$ 135,483	92
93			93
94			94
95		$ 135,483	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number CARROLL COUNTY GOOD SAMARITAN CENTER # 0007344 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO
16. Rental Amount for movable equipment: $ 3,843 Description: Network Computer Equip - Admin, Technicare - Nursing
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number CARROLL COUNTY GOOD SAMARITAN CENTER # 0007344 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [X] YES
   - [ ] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM: [ ]
   - IN OTHER FACILITY: [ ]
   - COMMUNITY COLLEGE: [X]
   - HOURS PER CNA: 80

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM: [ ]
   - IN OTHER FACILITY: [X]
   - HOURS PER CNA: 40

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$ 1,440	$	$ 1,440
2	Books and Supplies		208		208
3	Classroom Wages (a)		1,622		1,622
4	Clinical Wages (b)		811		811
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests		183		183
9	TOTALS	$	$ 4,265	$	$ 4,265
10	SUM OF line 9, col. 1 and 2 (e)	$ 4,265			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	3
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	3

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number CARROLL COUNTY GOOD SAMARITAN CENTER # 0007344 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	Ln 10a, Col 3	978.33	hrs	$ 48,917		$	$	978	$ 48,917	1
2	Licensed Speech and Language Development Therapist	Ln 10a, Col 3	177.59	hrs	8,880				178	8,880	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	Ln 10a, Col 3	1652.29	hrs	82,615				1,652	82,615	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy			# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Exceptional Care Program										12
13	Other (specify):										13
14	TOTAL				$ 140,411		$	$	2,808	$ 140,411	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number CARROLL COUNTY GOOD SAMARITAN CENTER **#** 0007344 **Report Period Beginning:** 1/1/2005 **Ending:** 12/31/2005

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2005 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 60,983	$	1
2	Cash-Patient Deposits	10,730		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	281,187		3
4	Supply Inventory (priced at)	12,211		4
5	Short-Term Investments	1,608,887		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	3,604		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,977,602	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	5,720		13
14	Buildings, at Historical Cost	2,171,370		14
15	Leasehold Improvements, at Historical Cost	171,456		15
16	Equipment, at Historical Cost	872,256		16
17	Accumulated Depreciation (book methods)	(2,291,850)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	106,594		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Asset Mgmnt, CIP	135,650		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,171,196	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,148,798	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 62,500	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	12,492		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	183,696		30
31	Accrued Taxes Payable (excluding real estate taxes)	17,017		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Group Ins	(596)		36
37	Garnishments	119		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 275,228	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Annuities	5,000		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 5,000	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 280,228	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,868,570	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,148,798	$	48

***(See instructions.)**

Facility Name & ID Number CARROLL COUNTY GOOD SAMARITAN CENTER # 0007344 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,775,821	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,775,821	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	235,668	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 235,668	17	
	B. Transfers (Itemize):			
18	**DNR RST PROP/OPER/END-GEN**	(2,961)	18	
19	**CASH ASSET ASSESS-CO**	(74,601)	19	
20	**INTRA-CO N/A-NC**	(65,357)	20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$ (142,919)	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,868,570	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number CARROLL COUNTY GOOD SAMARITAN CEN # 0007344 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,395,007	1
2	Discounts and Allowances for all Levels	(804,500)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,590,507	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	326,767	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 326,767	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	653	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	11,968	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	64,874	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	13,331	19
20	Radiology and X-Ray	1,503	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 92,328	23
	D. Non-Operating Revenue		
24	Contributions	14,588	24
25	Interest and Other Investment Income***	93,889	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 108,477	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Nsg & Med Supplies	64,187	28
28a	Schedule Attached	21,738	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 85,925	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,204,004	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	577,979	31
32	Health Care	1,406,713	32
33	General Administration	786,079	33
	B. Capital Expense		
34	Ownership	153,716	34
	C. Ancillary Expense		
35	Special Cost Centers	1,179	35
36	Provider Participation Fee	39,004	36
	D. Other Expenses (specify):		
37	Purchased Services - Lab & Radiology	3,669	37
38	Rounding	(3)	38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,968,336	40
41	**Income before Income Taxes (line 30 minus line 40)****	235,668	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 235,668	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number CARROLL COUNTY GOOD SAMARITAN CENTER # 0007344 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,893	2,093	$ 46,412	$ 22.17	1
2	Assistant Director of Nursing					2
3	Registered Nurses	11,420	12,404	256,717	20.70	3
4	Licensed Practical Nurses	5,473	5,899	103,574	17.56	4
5	CNAs & Orderlies	54,542	58,870	529,498	8.99	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,821	1,997	22,480	11.26	9
10	Activity Assistants	3,961	4,236	28,598	6.75	10
11	Social Service Workers	2,125	2,239	28,892	12.90	11
12	Dietician					12
13	Food Service Supervisor	1,828	2,103	24,229	11.52	13
14	Head Cook					14
15	Cook Helpers/Assistants	13,837	15,156	124,913	8.24	15
16	Dishwashers					16
17	Maintenance Workers	4,498	4,841	47,345	9.78	17
18	Housekeepers	7,368	8,169	68,695	8.41	18
19	Laundry	4,901	5,675	51,378	9.05	19
20	Administrator	1,835	2,091	56,061	26.81	20
21	Assistant Administrator					21
22	Other Administrative	6,876	7,722	95,218	12.33	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,794	2,042	27,664	13.55	31
32	Other Health Care(specify)	6,781	7,893	118,081	14.96	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	130,953	143,430	$ 1,629,755 *	$ 11.36	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	93	$ 5,326	Ln 1, Col 3	35
36	Medical Director	16	2,400	Ln 10, Col 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		3,192	Ln 10, Col 2	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	49	2,774	Ln 11, Col 3	44
45	Social Service Consultant	49	2,774	Ln 12, Col 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	207	$ 16,466		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	8	$ 355	Ln 10, Col 3	50
51	Licensed Practical Nurses	8	312	Ln 10, Col 3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	16	$ 667		53

Facility Name & ID Number CARROLL COUNTY GOOD SAMARITAN CENT] # 0007344 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jennifer Dunk	Administrator	100	$ 54,257
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 54,257

B. Administrative - Other

Description	Amount
Admin & Acctng Services	$ 120,060
TOTAL (agree to Schedule V, line 17, col. 3)	$ 120,060
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
National Campus	Market Research	$ 3,600
Van Ostrand & Elvidge Kelley	Legal	2,995
National Campus	Medicare Cost Report Prep	600
National Campus	Medicaid Cost Report Prep	900
Maxfield Research	Admin Consulting	6,388
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 14,483

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 50,183
Unemployment Compensation Insurance	6,399
FICA Taxes	122,137
Employee Health Insurance	129,998
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Staff Pension	30,452
Employee Recruitment - Nursing	496
Admin/Consultant Savings	2,100
Taxable Gifts	58
TOTAL (agree to Schedule V, line 22, col.8)	$ 341,823

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	6,288
Health Care Worker Background Check	
(Indicate # of checks performed)	
Public Relations	2,526
Dues - Reimbursable	4,498
Publications	1,139
Newsletter - Admin	1,508
Less: Marketing/Res Dev	(7,871)
Less: Public Relations Expense	(2,526)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 5,562

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 2,856
In-State Travel	484
Seminar Expense	703
Less: Out of State Travel	(2,856)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,187

**See instructions.

Facility Name & ID Number CARROLL COUNTY GOOD SAMARITAN CENTER # 0007344 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	HEATING	1/02	$ 1,738	10	$	$ 174	$ 174	$ 174	$ 174	$ 174	$ 174	$ 174	$ 174
2	HEATING	4/02	1,288	10		129	129	129	129	129	129	129	129
3	HEATING	1/01	219	10		22	22	22	22	22	22	22	22
4	PLUMBING	2/01	910	10		91	91	91	91	91	91	91	91
5	WALLPAPER	7/01	230	5		61	61	61	23				
6	PAINT	8/01	390	5		102	102	102	49				
7	AIR CONDITIONING	9/01	511	10		51	51	51	51	51	51	51	51
8	AIR CONDITIONING	10/01	1,841	10		184	184	184	184	184	184	184	184
9	AIR CONDITIONING	2/01	901	10		90	90	90	90	90	90	90	90
10	PLUMBING	4/01	87	10		9	9	9	9	9	9	9	9
11	PLUMBING	4/01	5,879	10		58	58	58	58	58	58	58	58
12	HEATING	5/01	152	10		15	15	15	15	15	15	15	15
13	PLUMBING	8/01	1,402	10		140	140	140	140	140	140	140	140
14	PLUMBING	1/03	1,787	10		179	179	179	178	178	178	178	178
15													
16													
17													
18													
19													
20	TOTALS		$ 17,335		$	$ 1,305	$ 1,305	$ 1,305	$ 1,213	$ 1,141	$ 1,141	$ 1,141	$ 1,141

Facility Name & ID Number CARROLL COUNTY GOOD SAMARITAN CENTER # 0007344 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report?
If YES, give association name and amount. **Life Services Network, $3604**

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **7.5 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **13,370** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **NO** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **39,004**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? **YES** Indicate the amount. $ **11,967**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **YES**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **19%**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **HENRY SCHOLTEN & COMPANY** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **YES** If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.